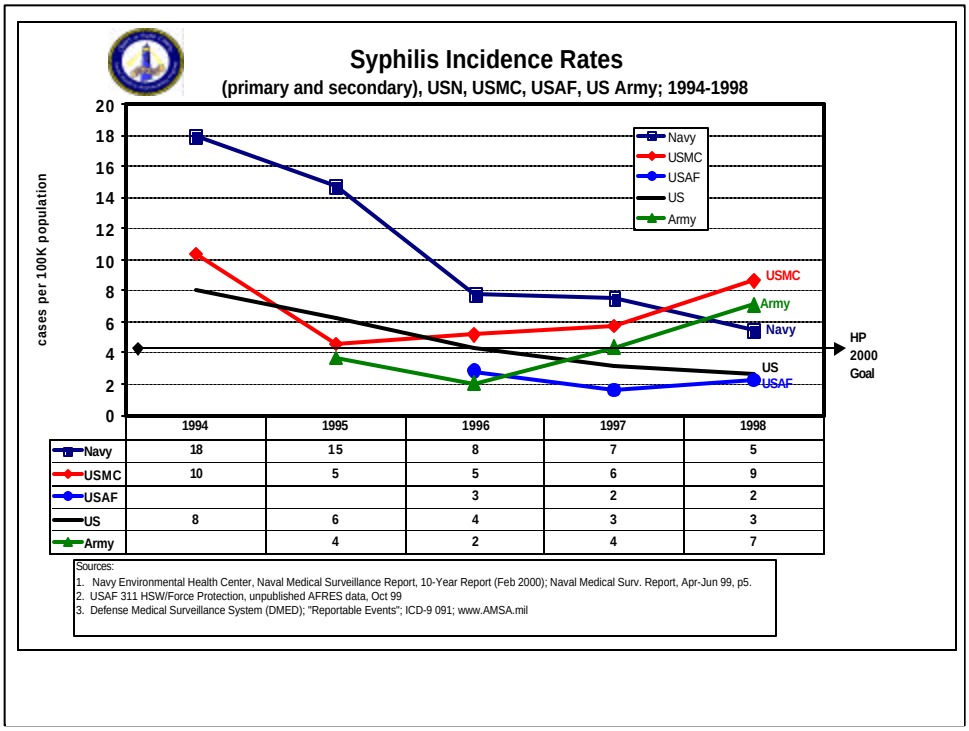


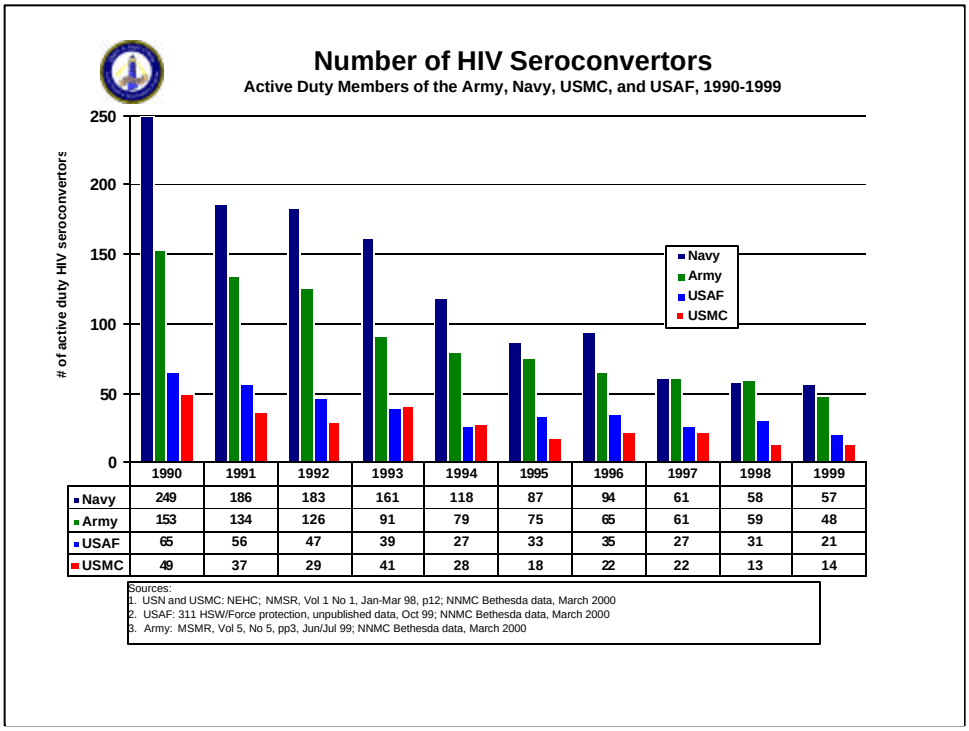
Primary and Secondary Syphilis cases among active duty members of the Army, Air Force, Navy, and Marine Corps, 1994-1998.

The DoD and DHHS Healthy People 2000 target of not more than 4 cases of primary and secondary syphilis per 100K population was exceeded in 1998 by US Navy, US Army, and USMC.

The increase in the USMC case rate represents an increase from 9 cases in 1997 to 15 cases in 1998, and may reflect improvements in the use of the Navy electronic reporting system. Currently, the military services are implementing a new reporting system to enhance surveillance efforts. Whether or not increases in reported cases in 1998 are a result of the new system remains to be established.

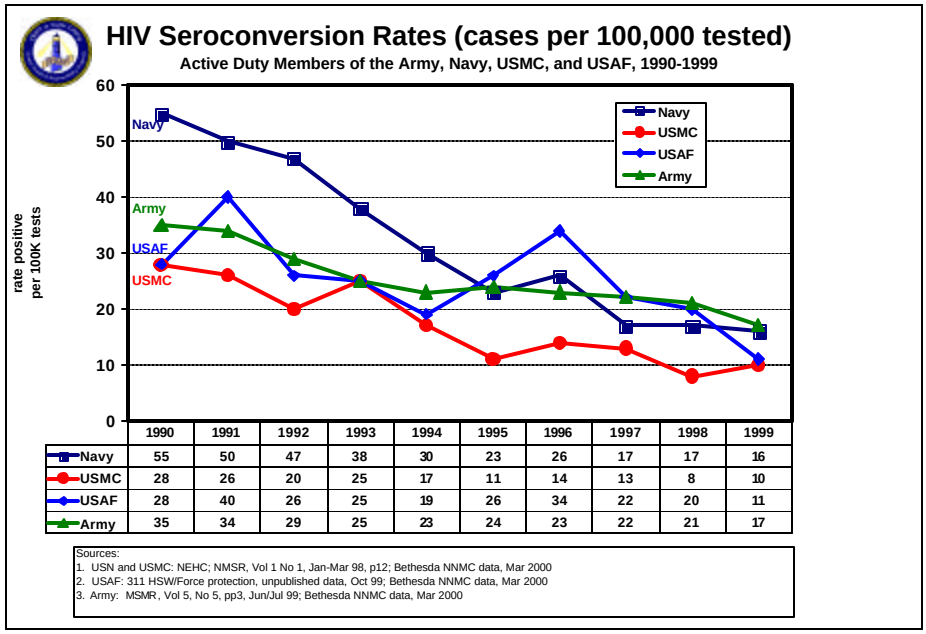
Through 1998, Navy and Marine Corps syphilis cases were typically reported by the appropriate regional Navy Environmental & Preventive Medicine Unit. These NEPMUs are located at Norfolk, VA (#2), San Diego (#5), Pearl Harbor, HI (#6), and Sigonella Italy (#7). During the 10-year period from 1988-1997, over 57% of all cases were reported by NEPMU2, which covers units stationed all along and ships deploying from the Atlantic and Gulf coast. NEPMU5, 6 and 7 reported 22%, 18% and 2%, respectively.

Military syphilis case data are derived from 3 separate passive reporting systems. These data suggests the presence of a problem that deserves further attention.



Number of HIV Seroconvertors Among Active Duty Members of the Army, Navy, USMC, and USAF; 1990-1999

Note that these data are **not** rates. They are numerator data **only**. These data can **not** be used alone to draw conclusions about HIV infection in these populations. These data do demonstrate (and quantify) that new HIV infections continue to occur in all of the military services.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Navy	55	50	47	38	30	23	26	17	17	16
USMC	28	26	20	25	17	11	14	13	8	10
USAF	28	40	26	25	19	26	34	22	20	11
Army	35	34	29	25	23	24	23	22	21	17

Sources:
1. USN and USMC: NEHC; NMSR, Vol 1 No 1, Jan-Mar 98, p12; Bethesda NNMC data, Mar 2000
2. USAF: 311 HSW/Force protection, unpublished data, Oct 99; Bethesda NNMC data, Mar 2000
3. Army: MSMR, Vol 5, No 5, pp3, Jun/Jul 99; Bethesda NNMC data, Mar 2000

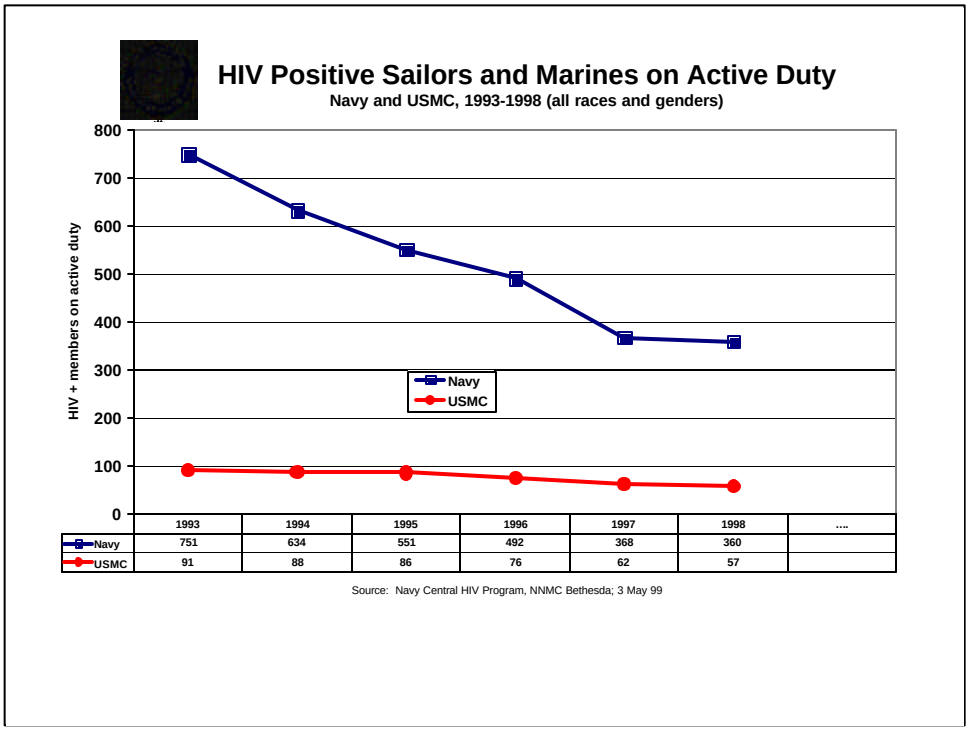
HIV Seroconversion Rates (cases per 100,000 tested)

Active Duty Members of the Army, Navy, USMC and USAF; 1990-1999

HIV screening policies of the Army, Navy/USMC, and USAF differ somewhat, and should be taken into account when comparing data. Standard policies for all services require screening of active duty members upon presentation in prenatal clinics, STD clinics, drug or alcohol abuse incidents, occupational blood exposure incidents, and diagnosis of active tuberculosis. All also screen medical personnel annually, and all members prior to separation/retirement and prior to overseas deployment/assignment.

In addition to these standard policies, the Army screens all members not less than biennially while the Navy and USMC conduct annual screening of members assigned to overseas or deployable units.

These policies are given in DoD Directive 6485.1 (all services), AFR 48-135 (Air Force); AR 600-110 (Army); and SECNAVINST 5300.30C (Navy). The policy variations yield different levels of screening coverage. The average number HIV tests conducted per 1000 active duty members from 1990-1999 by service were: USMC=903, Navy=828; Army=605; USAF=363. Screening fewer people at low risk (I.e. universal biennial screening) might have some impact on seroconversions rates compared to more highly targeted screening (i.e. incident-based screening). Hence, caution must be used when comparing data between the Army, Navy/USMC, and USAF.

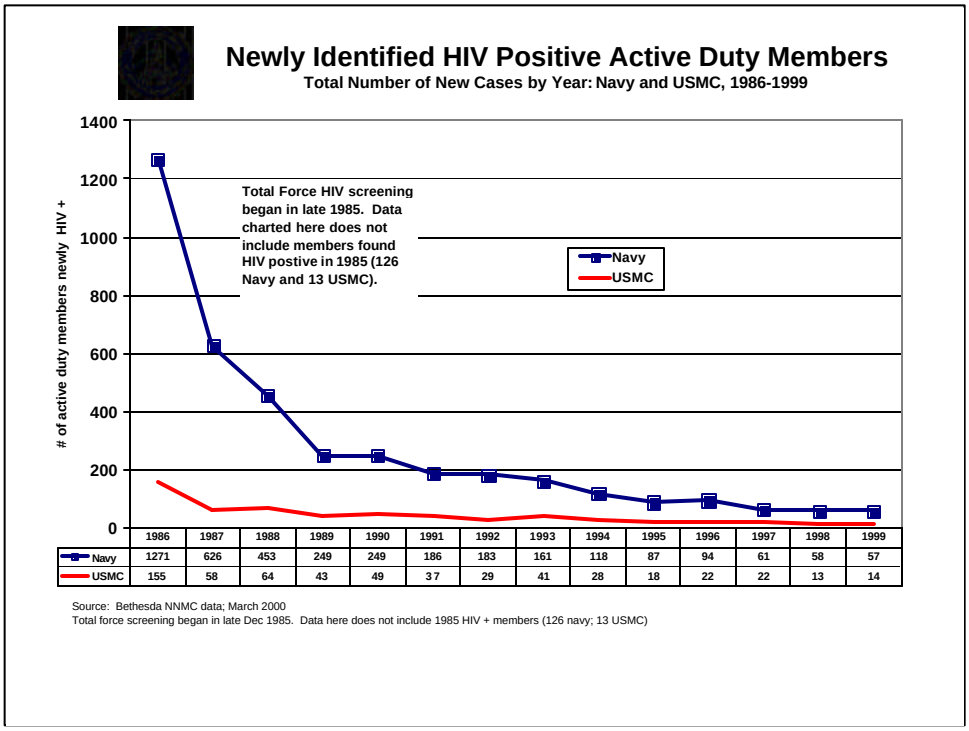


Number of HIV Positive Sailors and Marines on Active Duty by Year; 1993-1998

Decisions to retain or separate Sailors and Marines from active duty are governed by Department of Defense Directive 6485.1, and Secretary of the Navy Instruction 5300.30C. HIV positive members are retained on active duty provided they show no evidence of clinical illness or immunologic or neurologic impairment related to their HIV infection.

These members are assigned only within the United States (including Hawaii, Alaska, and Puerto Rico). They are assigned to a unit **not** normally programmed for deployment, and one which is within 300 miles of a Naval Medical Treatment Facility to receive therapies and periodic clinical evaluations.

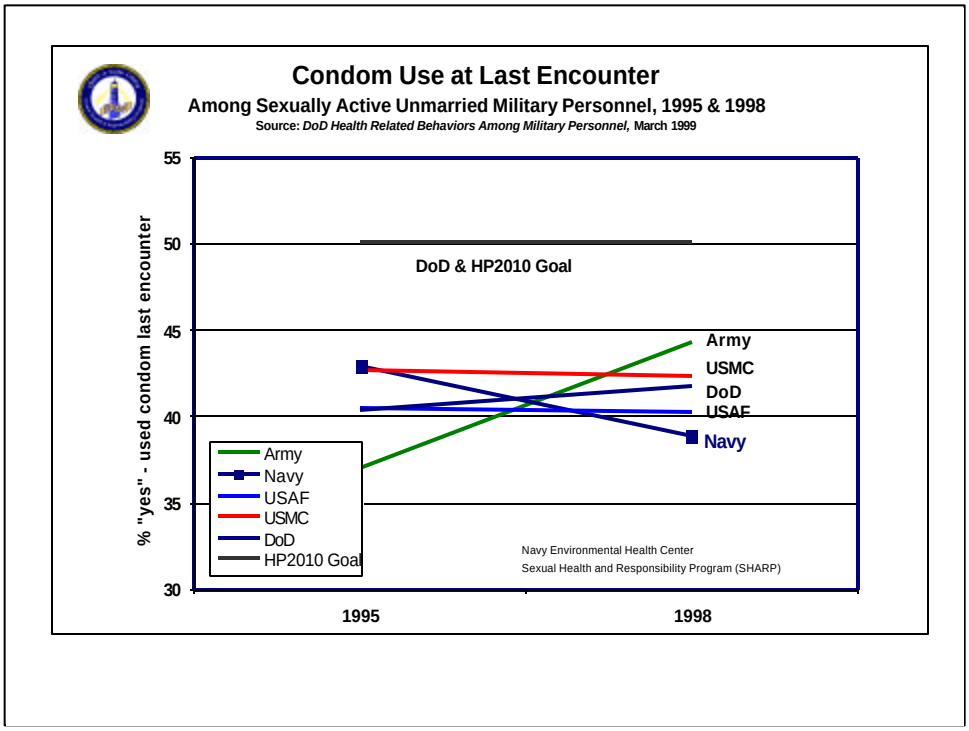
Combination therapies to improve health of HIV positive members may have contributed to the "leveling off" seen in 1997-98. These therapies might actually increase the prevalence of HIV positive Sailors and Marines on active duty in future years.



Newly Identified Cases of HIV Infection Among Active Duty Sailors and Marines; 1996-1999

HIV testing of all active duty Sailors and Marines was begun in late 1985. The total force screening program sought to test all active duty members at least once within the first 2 years, and again during the next 2 years.

Note that this graph plots newly identified infections, not necessarily newly acquired infections. The distinction is important, particularly in the earlier two or three years, where the number of positive members is more an indication of pre-existing plus newly acquired HIV infection (prevalence). Predictably, the first few years of testing identified higher numbers of HIV positive members. Since all new accessions into the Navy and USMC are screened for HIV infection (and people who are positive are excluded), the number of HIV infections identified in later years is more an indication of newly acquired infections (annual incidence).



Self-reported Condom Use at Last Sexual Encounter

by Unmarried Active Duty Military Personnel in 1995 and 1998.

These data indicate that use of a condom at last sexual encounter among sexually active unmarrried Sailors dropped from 42.9 to 38.9 percent (lowest in DoD) from 1995 to 1998. The Department of Health and Human Services and DoD goals for Healthy People 2010 is **50% or more**.